

BLUE CROSS BLUE SHIELD (BCBSM) BACKGROUND INFORMATION

*Information from the 2001 Michigan Office of Financial and Insurance Services
(OFIS) Targeted Internal Review of BCBSM*

SCOPE OF TARGETED INTERNAL REVIEW

The targeted internal review consisted of a review of Blue Cross and Blue Shield of Michigan's most recent filings with the Insurance Division and supplemented by specific topics and concerns that were raised by Insurance Division staff or other interested parties within the state. The information reviewed included standard required filings with the Insurance Division in addition to specific information requested from Insurance Division staff.

OVERVIEW OF COMPANY

Blue Cross and Blue Shield of Michigan (BCBSM or the Company) is incorporated as a nonprofit health care corporation under the provisions of Public Act 350 of the Michigan Insurance Laws. Hospital, medical and other health benefits are provided under contracts with subscribers. Under the Act, the Company's primary purpose is to provide health care coverage to the residents of Michigan at fair and reasonable prices so that any person or group that applies for coverage is accepted. The Company must offer coverage to individuals and groups without medical, age or gender underwriting.

The Company maintains a strong market share (currently greater than 50%) among all health companies in Michigan. The Company has experienced steady membership growth in each of the past four years and maintains a leading position in all four major product segments: managed traditional, preferred provider organization, point of service and health maintenance organization (HMO).

The Company contracts with participating hospitals, physicians, specialists, pharmacies and other health care organizations. The largest group of providers are participating hospitals that number about 185.

The Company processes provider claims on eight main claims systems: Blue Cross (mostly hospital facility related claims), Blue Shield (physician/specialist), drugs (pharmacies), vision, hearing, master medical and major medical. Generally, the Blue Cross (or Facility) claims system processed the greatest dollar volume of claims. The Company also participates in a consortium of other Blue Cross and Blue Shield plans in the National Account Service Company (NASCO). NASCO process certain claims, generates claim payments and provides other accounting services related to the Company's participation in "national business" with other Blue Cross and Blue Shield plans.

FINANCIAL SUMMARY

At 12/31/00 the Company remains financially stable and profitable. The Company has a Bests rating of A- (excellent). The Company maintains a leading market share in Michigan, expansive distribution channels and strong provider relationships. The Company's bottom-line earnings have remained favorable buoyed by a stable investment portfolio. The investment portfolio includes conservative debt instruments and generally well-performing subsidiary investments. The debt instruments and subsidiary investments generate investment income and dividend income, respectively, which has offset more recent unprofitable underwriting results.

In brief, the Company reports total assets of \$3.7 billion reflecting invested assets of \$1.8 billion and non-invested assets of \$1.9 billion. Invested assets reflects debt instruments (high quality bonds) of \$824.3 million, equity investments (generally wholly-owned affiliated stocks) of \$579.0 million, real estate (all Company occupied) of \$211.6 million and short-term investments (generally high quality money market funds) of \$159.2 million. Only real estate and certain affiliated equity investments do not generate investment income.

Non-invested assets of \$1.9 billion largely represent receivable balances. The receivables include advances to providers (money owed to the Company because interim payments to hospitals exceeded the hospital's submitted claims) of \$253.2 million, amounts due from administrative service contract (ASC) groups (receivable representing actual billings on ASC business) of \$61.3 million, ASC unpaid claim receivables (the receivable that offsets the actuarial estimate of ASC claim liabilities) of \$571.1 million, and the Area rate stabilization receivable (representing the capitalization of operating losses within the Area business segment) of \$398.9 million. Other receivable or non-invested balances not mentioned are either immaterial, reflect journal entry reclassifications or were required by Generally Accepted Accounting Principle (GAAP) accounting rules. The "true" receivables, such as the advances to providers and amounts due from ASC groups generally are collected on a timely basis. The Area Rated rate stabilization reserve (RSR) receivable, however, continues to grow (again, reflecting on-going Area operating losses), and is, by the way, one of the principal driving forces behind the current examination and actuarial review.

Liabilities of \$2.4 billion at 12/31/00 generally represent liabilities for unpaid claims. The claim liabilities generally represent reserves for ASC business, reserves for underwritten business, reserves for hospital outliers and a stop-loss reserve. Actuarial testing performed during the examination supports the adequacy of reserves. Other liabilities are discussed in more detail below. These include a provision for experience rating refunds (reflecting favorable claims experience for certain ERS groups) and advances to providers (reflecting claim costs that exceeded interim payments to hospitals).

The Company reported net income of \$65.4 million at 12/31/00, down from net income of \$89.1 million one year earlier. The change reflects, among other factors,

the current capping of the Area Rated RSR receivable. In other words, underwriting losses now reflect an increase in claims expense as the Area Rated losses are being expensed in the income statement rather than capitalized on the balance sheet. Net income continues to be affected by the HMO subsidiary's on-going operating losses.

Surplus of \$1.2 billion at 12/31/00 remains within the target contingency reserve level (i.e., not less than 65% nor more than 150% of target). Surplus is buoyed by the capitalization of the Area segment losses and from favorable market performance and affiliated dividend income.

As the ongoing examination and actuarial review have supported, the principal concern continues to be poor performance in sections of the Area Rated market segment. The actuarial component of the review will target the concerns and recommend possible solutions. In the short-run, the Company can tolerate certain underwriting losses by investing premium and thereby earn investment income to offset the underwriting losses.

SUBSIDIARIES

The Company is the ultimate controlling parent of the following organizations:

The Accident Fund Company is a wholly owned property casualty insurance company that writes workers' compensation insurance primarily for small to mid-sized companies located in Michigan. The Accident Fund Company is the largest writer of workers' compensation in Michigan with a market share of about 14%. The Company also administers, for a fee, self-insured workers' compensation programs, and participates as one of six servicing carriers in the Michigan Workers' Compensation Placement Facility. The Company acquired The Accident Fund Company in 1994 at a cost of \$272.1 million (representing a purchase price of \$262.1 million and capitalization of \$10 million). Goodwill paid for The Accident Fund was \$101.5 million.

Blue Care Network (BCN) of Michigan is a wholly owned mixed model health maintenance organization. BCN of Michigan provides health care services to subscribers through contracts it has entered into with various physician groups, hospitals, and other healthcare providers.

Network Care is a wholly owned subsidiary incorporated in 1984 as an alternative health care and delivery system that has no medical liability risk, but does have risk associated with rating its products. Network Care offers certain medical and dental care products to its members through an agreement with BCN of Michigan. Network Care has two wholly owned subsidiaries, Blue Cross and Blue Shield of Michigan Foundation and BCN Service Company (a TPA for various managed care programs). Note that Network Care changed its name to Blue Care of Michigan, Inc. effective March 2, 2001.

PPOM, LLC is a network of physicians, hospitals and other health care providers that have joined together to offer health care services at affordable prices. PPOM was formed by the Company in 1997 and then merged with Preferred Provider Organization of Michigan, L.L.P., a Delaware limited partnership, whose partnership interests it had acquired. The use of PPOM preferred providers is generally offered to eligible participants as an option to their traditional health benefit plan. Financial incentives are offered to employees and covered dependents to encourage the use of network providers. There are over 950,000 patients that are eligible to use the system. PPOM is not an entity regulated by the Michigan Insurance Division. PPOM has one wholly owned subsidiary, Flora Midwest, L.L.C., which is a preferred provider organization that operates in the state of Ohio.

Health First, Inc. is a 50% owned for-profit corporation formed in 1986 through an alliance with Borgess Health Alliance, an affiliate of Borgess Hospital in Kalamazoo whose purpose is to facilitate contracts between certain hospitals and BCN of Michigan through an administrative services agreement.

Global Health Options is a Michigan based integrated health delivery system acquired in 1995.

BUSINESS SEGMENTS

The Company offers underwritten coverages and administrative service contracts as well as HMO coverage through BCN of Michigan, preferred provider organization (PPO) and point of service managed care options. The underwritten market segment includes both groups and individuals in the following categories: Experience Rated, Area Rated, Industry Rated, Medigap, Group Conversion and Non-Group.

Administrative Service Contracts (ASC)

ASC business consists of groups who self-insure for health care coverage, but contract with the Company to supply various administrative services such as processing claims. Major ASC clients include the state of Michigan, Federal Government, General Motors, Ford and Chrysler. The Company is reimbursed for costs incurred and also makes a small profit. ASC business is nearly risk free and not designed to be materially profitable. The administrative service contract segment accounts for \$4.8 billion, or about 53% of the Company's total subscriber income for which it earned a profit of \$6.6 million.

The sheer volume of this business impacts and distorts the Company's balance sheet. For example, the Company reports a receivable (and a corresponding liability that represents the actuarial estimate of the IBNR claim liability) of over \$561 million for the monies it will receive from ASC groups. Although it is reported as a receivable, it is not a receivable in the traditional sense because it does not represent actual billings. The Company does record an amount that represents actual billings on ASC business, "amounts due from ASC groups". This amount is significantly smaller at \$56 million.

The administrative service contract segment is subdivided into the auto, national and local customer segments with the auto segment being the largest. The Company also participates with other states' Blue Cross and Blue Shield plans in providing coverage to either Michigan based companies with employees residing in other states or a company based in another state with employees residing in Michigan. This business is referred to as "national business" and the coverage provided can either be underwritten or on an administrative services only basis.

Questions were raised regarding the Company's lack of aging schedules for amounts due from ASC groups. The Company contends that although these receivables may be material, they are typically collected very fast and that "the risk of uncollectible balances is negligible". The Company goes on to state "the risk of non-payment is remote so that the dollar amount of ASC receivables that is uncollectible is essentially \$0". At 10/01/00, the Company had only \$80,000 due from ASC groups that were over 30 days past due.

The inclusion of ASC business in the Company's annual statement has stirred debate for years. It certainly isn't a true insurance product. The National Association of Insurance Commissioners (NAIC) recognizes this fact and its new financial statement for health entities prohibits the reporting of ASC premiums and expenses. Those entities with ASC business will now report in its income statement only the overall profit derived from ASC business. This treatment is under consideration with the Insurance Division. The impact, however, of removing ASC business from premium revenue may impact the current subsidy transfer.

Given the Company's admission of the risk associated with ASC business, it would seem that the risk factor (which is part of the calculation that determines the target contingency reserve balance) assigned to this block of business needs to be re-evaluated.

Experience Rated

Experience Rated includes those employer groups whose rates are based on the "experience" or total use of health care benefits by the group's members during a coverage period. Usually, the coverage period is one year. Groups of 100 or more members must be Experience Rated. The Company has three different Experience Rated formulas with different options depending on the size of the group. The Experience Rated underwritten segment represents \$1.6 billion, or about 18% of the Company's total subscriber income.

Area Rated

Area Rated includes groups and individuals in one of five defined geographic areas in Michigan whose rates are based on their total use of benefits. Groups of 99 or fewer members as well as non-group subscribers must be Area Rated. The Area Rated underwritten segment represents \$1.5 billion, or about 17% of the Company's total

subscriber income. The Area Rated segment has experienced the highest rate increases over the last five years and is still experiencing an underwriting loss.

Under P.A. 350, the Company is allowed to recover prior year losses and must return prior period gains on Area Rated business through future rate adjustments. MCL 550.1609(5) requires that each line of business, over time, be self-sustaining. Additionally, MCL 550.1205 allows for assessments for plan wide viability in the event certain triggers are made. It is the Insurance Divisions interpretation that these two statutory sites combined give the Company the authority to recover past losses with future rates increases. As a result of the ability to recover these past losses the Company has capitalized the losses experienced over the past five years as an asset called Rate Stabilization Reserve (RSR).

FAS 71 supports the concept of the recoverability past losses through future rate increase and is geared towards the heavily regulated utility market. FAS 71 allows the Company to create the RSR because in theory it will be able to pass these losses on to its Area Rated customers in the form of future rate increases. To our knowledge no other BCBS plan or health care insurer utilizes FAS 71 to capitalize losses.

The RSR has grown markedly in the past five years from an \$81.2 million payable in 1995 to a \$399 million receivable in 1999. The RSR continued to increase during 2000 to \$465 million but the Company now reports a contra-liability of \$66 million for RSR Impairment resulting in an unchanged net RSR balance of \$399 million.

In order to better understand what was causing these significant losses, we attempted to acquire a breakdown of the RSR by group size (sole proprietors, 2-9, 10-99). However, the Company contends that it does not have this type of breakdown since it doesn't rate groups by group size. Given the magnitude of the losses in this business, it seems unusual that the Company not have at its disposal this type of information.

The Company was able to provide a breakdown by geographic rating area, which was also requested. There are eight geographic rating areas, though areas 2 and 6, and areas 4 and 7, are combined for rating purposes since they at one time had similar loss patterns.

For 2000, the following breaks down the RSR by area:

<u>Area</u>	<u>Revenue</u>	<u>RSR</u>	<u>RSR/Revenue</u>
1	\$675,660,170	\$151,954,233	.225
3	\$126,459,085	\$47,929,655	.379
5	\$106,054,021	\$39,331,803	.371
2 and 6	\$267,094,557	\$68,762,450	.257
4 and 7	\$306,863,155	\$130,127,121	.424
8	\$56,665,418	\$26,837,772	.474

For 1999, the following breaks down the RSR by area:

<u>Area</u>	<u>Revenue</u>	<u>RSR</u>	<u>RSR/Revenue</u>
1	\$611,755,748	\$152,133,669	.249
3	\$116,033,339	\$34,958,014	.301
5	\$95,048,134	\$31,941,784	.336
2 and 6	\$228,787,211	\$61,801,804	.270
4 and 7	\$272,646,826	\$98,848,892	.363
8	\$47,328,616	\$19,254,257	.407

While area 1 (to oversimplify, Metro Detroit) is responsible for the greatest dollar amount of the RSR (\$152 million), it is not the worst performing area of late. Areas 4 and 7 (roughly Grand Rapids and the northern Lower Peninsula) and area 8 (the Upper Peninsula) have produced the most unfavorable results.

In the preliminary actuarial review of the RSR, it was noted that the coupling of areas 2 with 6 and 4 with 7 no longer appears to make sense for rating purposes. Results show that losses in area 6 are dramatically worse than in area 2. Likewise, the experience in area 7 is much worse than in area 4. Though it is unclear who should approach the matter of changing the current rating coupling, this uncoupling should be pursued. Current practice effectuates an unforeseen subsidization by one area of another. While the merits of such a subsidy aren't being disputed, it does appear the subscribers in the profitable area should not suffer rate increases based on the experience in the unprofitable area to which it no longer shares loss characteristics. If subsidies are indeed a desired outcome, perhaps adding other areas to the current couplings merits discussion.

Industry Rated

The Industry Rated underwritten segment represents \$797 million, or about 9% of the Company's total subscriber income. The segment is a component of the Area Rated underwritten segment and classifies groups of under 100 members into eight different industry segments by Standard Industry Classification (SIC) code. Groups that do not fall within one of the eight different industries are then classified with one of eight geographic regions and comprise the Area Rated underwritten segment discussed above. Industry Rated groups are rated prospectively and are not a function of the Area Rated RSR balance also discussed above.

Medigap

The Company's individual Medigap subscribers have also experienced very stable premiums over the past several years, due mainly to the senior subsidy, which transfers up to 1% of the Company's premium income from other customers to Medigap subscribers. As long as revenue keeps growing, the 1% senior subsidy will also grow as a dollar amount. However, if Medigap costs increase faster than revenue, the senior subsidy will no longer be able to cover the 30% of Medigap

premium costs that it now does, which will cause Medigap subscriber premiums to rise.

Group Conversion

Group conversion include those individuals who terminate their coverage with an organization having the Company's group health coverage, but are entitled to continue as subscribers by paying for their own coverage at special rates. The group conversion underwritten segment makes up less than 1% of the Company's total subscriber income.

Non-Group

Non-group consists of individual subscribers who pay for their own coverage. The non-group underwritten segment accounts for less than 1% of the Company's total subscriber income.

BCBSM non Medicare-eligible individual subscribers in the non-group business segment have not had a premium rate increase since 1997, and those in the group conversion segment have not had a premium rate increase since 1993.

BASIS OF ACCOUNTING

The Company is required to report in accordance with Generally Accepted Accounting Principles (GAAP) pursuant to MCL 550.1205(1). The Company files the NAIC annual statement on both a GAAP and Modified GAAP / Statutory accounting basis. All quarterly financial statements are filed on a Modified GAAP / Statutory accounting basis. The annual statement filed on a GAAP basis identifies its consolidated nature and discloses all consolidating entries. Modified GAAP / Statutory financial statement filings are based upon guidelines promulgated by the Commissioner.

FINANCIAL OVERVIEW

ASSETS

The Company reports total assets of \$3.7 billion at 12/31/00, up about \$196.1 million from total assets of \$3.5 billion at 12/31/99. The following chart identifies invested assets:

<u>INVESTED ASSETS</u>	<u>12/31/00</u>	<u>12/31/99</u>
Bonds	\$824,339,310	\$643,038,809
Common Stocks	579,008,195	559,803,063
Real Estate	211,583,618	209,681,910
Cash	(187,771,950)	(175,628,428)
Short-term Investments	159,192,605	234,396,796
Other Invested Assets	<u>185,532,084</u>	<u>213,774,751</u>
Total Invested Assets	\$1,771,883,862	\$1,685,112,617
Miscellaneous Assets	113,341,590	98,051,734
Aggregate Write-in Assets	<u>1,784,141,211</u>	<u>1,690,110,144</u>
Total Assets	\$3,669,366,663	\$3,473,274,495

Bonds

The bond portfolio of \$824.3 million is primarily made up of U. S. Treasury Bonds, Mortgage Backed Securities and Corporate Notes. All bonds are publicly traded and almost all are rated “1” by the NAIC Securities Valuation Office (SVO). Bonds increased \$181.3 million, or 28.2%, during the year. The increase reflects several factors, including dividends received from affiliates in the amount of \$73.5 million and a decrease in short-term investments of \$75.2 million.

U.S. Government bonds represent \$126.0 million or 15.3% of total bonds. All are U.S. Treasury Notes that are fully backed by the U.S. Government. There is no risk of default on these bonds. Mortgage backed securities representing obligations of the Federal Home Loan Mortgage Corporation and FNMA, while not backed by the U.S. Government, are all rated class 1 and pose little risk of default. These pools of mortgage backed securities represent \$456.3 million or 55.4% of total bonds. Finally, corporate notes consisting of industrial and miscellaneous obligations are single issuer obligations of generally well-known corporations. Corporate notes represent \$241.1 million or 29.2% of total bonds. With one immaterial exception, they are all rated “1” by the SVO.

The statement values for bonds are valued in accordance with FASB 115 (i.e., GAAP). Because the Company has classified its debt securities as ‘available for sale’, its debt and equity securities are carried at market value.

Common Stock

The common stock portfolio of \$579.0 million principally represents wholly owned subsidiaries BCN of Michigan, the Accident Fund and Network Care and the net unrealized gains or losses on those investments. These subsidiaries are valued on the equity method of accounting, a statutory concept applied to the Company, because under true GAAP the entities would be consolidated and there would be no picture of the Company on a stand-alone basis. The Company’s unaffiliated common stock portfolio represents well known companies and represents \$34.8 million. The change in common stock was not material during the year. Unaffiliated common stock investments represent just 6% of total common stock and generally represent investments in blue-chip companies.

The Accident Fund paid the Company \$35.0 million in dividends during 2000. The Accident Fund is currently reported at a market value of \$466.4 million, an increase of \$194.3 million from the date of acquisition.

BCN of Michigan represents the merger of four previously affiliated but generally independent BCBSM health maintenance organizations. The merger was effective February 1, 1998. BCN of Michigan has lost over \$100 million since the merger reflecting consolidation expenses as well as losses through the normal course of operations.

Real Estate

Real estate of \$211.6 million at 12/31/00 represents properties owned and occupied by the Company. The portfolio remains relatively unchanged from the prior year book value of \$209.7 million. The real estate portfolio does not produce any income for the Company. The market value of the portfolio is \$319.4 million representing a 50% increase over the book value (which is not reflected in the balance sheet). The Company is currently attempting to sell its McNary office building in Detroit. It has a book value of \$1.4 million and a market value of about \$1.7 to \$1.9 million. The Company indicates that there are no plans to significantly increase or improve the real estate holdings other than expenditures required to maintain the current facilities in good working condition. There are also no plans for any sale/leaseback financing. All real estate purchases and sales require the approval of the Corporation's Finance Committee and Board of Directors.

Cash

The Company reports negative cash of \$187.8 million because it maintains a zero balance checking account to pay benefit expenses. The negative cash balance on the annual statement represents outstanding checks that have been issued by the Company that have not been presented for payment at month-end. The Company reclassifies outstanding checks as a liability and books an offsetting asset amount as Bank Overdrafts Reclassified as Liabilities.

Short-term Investments

Short-term investments of \$159.2 million are invested in money market funds. As noted above, short-term investments dropped \$75.2 million during the year. The decrease is offset by the change in bonds during the same period.

Other Invested Assets

Other invested assets of \$185.5 million principally represent the Company's investment in PPOM. Other invested assets declined \$28.3 million or 13.2%, from \$213.8 million at 12/31/99. Almost 78% of other invested assets represent the Company's wholly owned affiliate, PPOM, Inc. The decrease from 12/31/99 to 12/31/00 of \$28.3 million is principally reflected in the change in PPOM's book value. The drop reflects return of capital and dividend distributions from PPOM. Specifically, PPOM made a distribution of \$24.2 million representing a return of capital and a dividend distribution of \$14.3 million (both representing a decrease in the value of PPOM).

The Company was given Insurance Division approval for PPOM to acquire the PPO business of SelectCare, Inc. PPOM is expected to fully fund the \$25.9 million purchase price.

Finally, the Company made a \$12 million investment in PersonalPath, a company in Upper Saddle River, New Jersey. In addition, the Company sold several investments either at cost or a small loss and wrote off a \$2.7 million investment in Healthtrac, a San Jose, California company.

Miscellaneous Assets

Miscellaneous assets consist of premiums receivable, EDP Equipment, Interest Income Due and Accrued and Receivable from Parent, Subsidiaries and Affiliates. These amounts represent an immaterial portion of the Company's asset base and have not fluctuated materially during the year.

Aggregate Write-ins for Other than Invested Assets

Aggregate write-ins for other than invested assets increased \$94.0 million or 5.6%, from \$1.7 billion at 12/31/99 to \$1.8 billion at 12/31/00, and represent over 50% of total assets. The following represents the more significant write-in items included in that line:

<u>NON-INVESTED ASSETS</u>	<u>12/31/00</u>	<u>12/31/99</u>
Advances to Providers	\$253,180,397	\$172,869,563
Offsetting Premium Rec.-Reimb Acct	571,135,890	541,791,262
Bank Overdrafts Reclassed as Liabilities	187,771,950	175,628,428
Rate Stabilization Receivable	398,874,000	398,874,000
Securities Lending Collateral Receivable	147,505,968	204,573,831

Advances to Providers are made on a periodic basis under the terms of the provider agreements, these advances are called Blue Interim Payments. The advances represent either the net asset or net liability (on a hospital by hospital basis) that exists between the Company and the providers. The amount is derived by the following formula:

$$\begin{aligned} & \text{Incurred and Vouched Claims} \\ & - \text{Blue Interim Payments} \\ & = \text{Advances to Providers} \end{aligned}$$

The difference between Blue Interim Payments and Incurred and Vouched Claims is greater than zero (which means that the weekly Blue Interim Payments exceeded the incurred and vouched claims at month end). The Insurance Division requires the Company to segregate the asset and liability components of advances to providers on the balance sheet rather than reporting a net number. With respect to the \$253.2 million asset, it represents the amount of money owed to the Company from hospitals because the weekly interim payments exceeded the hospital's claims submitted at month-end. The Company will point out that they are in a positive cash flow position with respect to hospital costs because there is an excess of Blue Interim Payments over vouchered claims that is less than the IBNR claims incurred by the hospitals. Note that the Advances to Providers asset of \$253.2 million increased \$80.3 million or 46.4%.

The Offsetting Premium Receivable—Reimbursement Accounts represent administrative service contract (ASC) receivables. These receivables represent the claim revenue that the Company will receive from ASC groups attributable to the established ASC IBNR liability that is reported on the books. Note that the

receivable does not represent actual customer billings that need to be collected. Under an ASC arrangement, for every dollar of claims incurred (both paid claims and IBNR) there is a corresponding recognition of revenue and the establishment of a receivable for the reimbursement that the Company will receive from the group. In other words, the asset represents the offsetting receivable to reimburse the actuarial estimate of the IBNR claim liability.

Bank Overdrafts Reclassified as Liabilities represents an offset to the negative cash of \$187.8 million, which reclassifies the balance to the liabilities page.

The Rate Stabilization Receivable (RSR) represents the Company's treatment with respect to operating losses incurred on its Area Rated line of business. The Company is deferring these losses to future periods when gains are expected to allow full recovery. This position has been upheld because the Company is regulated under state law and the rate setting formula allows the Company to recover losses in the determination of future years' rates. The Company applies FAS 71 (a GAAP concept) to defer these losses into future years (by booking a receivable that will diminish upon a recovery of those losses through the rate increase). The Company capped the RSR at \$398.9 million as of January 1, 2000. This suggests that collectibility of the full balance (\$464.9 million at 12/31/00) may be questionable. The difference of \$66.1 million at the end of the year is not reflected, therefore, as part of assets or surplus. These additional losses have instead been expensed in the income statement rather than capitalized in the balance sheet. Note that the Insurance Division instructed the Company to report the gross amount net of the capped amount in the statement to identify the portion capped and the true receivable balance. The Insurance Division and PricewaterhouseCoopers are reviewing the collectibility of RSR in a related project.

Finally, the Securities Lending Collateral Receivable represents FAS 125 treatment with respect to securities lending. An equal balance on the liabilities page offsets this asset. The Company is required to report, in accordance with FAS 125, an asset and a liability (gross up the balance sheet) for the collateral received equal to 102% of the securities on loan (generally overnight). The increase in the balance from the prior year reflects an increase in securities on loan. At year-end 1999, the Company had about \$200.5 million of securities on loan and received \$204.6 million of collateral.

LIABILITIES

Total liabilities were \$2.4 billion at 12/31/00, relatively unchanged from total liabilities at the prior year's end. There were no material fluctuations in any individual liability.

Aggregate Write-ins for Other Liabilities of \$915.1 million at 12/31/00 represents 38% of total liabilities. The following represent the more significant write-in items included in that line:

<u>LIABILITY</u>	<u>12/31/00</u>	<u>12/31/99</u>
Provision for Experience Rating Refunds	\$135,603,655	\$165,306,261
Bank Overdrafts	187,771,950	175,628,428
Advances to Providers	178,282,439	183,288,855
Securities Lending Collateral Payable	147,505,968	204,573,831
Pension and Other Post-retirement Liabilities	233,787,468	228,055,107

Provision for Experience Rating Refunds represents three major items. It consists of RSR credits for formula I and II group business, pharmacy rebates and hospital settlements (i.e., refunds). The decrease was not material during the year.

With respect to the RSR credits, this liability represents the sum of liabilities to each individual group that has a formula I or formula II rating arrangement and has paid premiums in excess of benefit payments. The Company returns the amounts to the groups in subsequent rating periods either in the form of cash payments or through premium rate credits. Note that there is an off balance sheet receivable for the groups that have had cumulative benefit payments in excess of premiums paid.

The liability for hospital refunds represent the difference the Company has initially charged groups (vouchered claims) vs. the ultimate actual cost for these services determined by the Company and the hospitals. The Company indicates that because it returns any excess charges made to groups over ultimate costs in the form of cash or premium rate credits through their RSR, the refunds included in this liability are obligations to groups once the hospital costs are finalized.

The liability for non-hospital refund liabilities primarily consists of prescription drug rebates that the pharmacies have rebated the Company based on utilization of brand name prescriptions. The monies are then returned to the groups in the form of cash or premium rate credits through their RSR. A small portion of this liability also represents miscellaneous monies collected by the Company for fraud recoveries, erroneous provider payments, etc. They are also returned to customers in a similar fashion as the drug rebates.

The Bank Overdrafts reflects the reclassification of negative cash to a liability line. See the Assets section above for more detail.

The Advances to Providers liability of \$178.3 million reflects that the claims submitted by the hospitals were greater than the weekly Blue Interim Payments made to the providers at month-end. In order to maximize leverage in the marketplace, the Company's current Participating Hospital Agreement provides for the Company to pay a weekly fixed amount that represents the hospital's anticipated weekly incurred medical costs (rather than pay claims as submitted). The Company also reports an asset for Advances to Providers—these are reported separately at the request of the Insurance Division. The decrease was not material during the year.

The Securities Lending Collateral Payable was reviewed in the Assets section above. GAAP reporting requires BCBSM to “gross up” the balance sheet for the Securities Lending asset and liability. Please see the additional comments made in the Assets section, above.

The Pension and Other Post-Retirement Liabilities reflects the Company’s post-retirement benefit obligation related to a defined benefit pension plan. The pension liability is determined under the provisions of FAS 87. The Company’s policy is to fully fund the pension plans to the extent permitted by the IRS and ERISA regulations. The liabilities are determined by Watson Wyatt, BCBSM’s consulting actuaries. Note that BCBSM also has on the books an unfunded accrued liability for anticipated retiree health care benefits as required by FAS 106. Under FAS 106, this amount is not required to be funded but is a pay-as-you-go plan. BCBSM’s actuary, Watson Wyatt, also determines the liability. The increase was not material.

INCOME STATEMENT

The Company reports net income of \$65.4 million at 12/31/00, down significantly from net income of \$89.1 million at 12/31/99. This change reflects, in part, the current capping of the Area Rated RSR.

The Company reports earned premiums of \$9.0 billion at 12/31/00, an increase of \$765.0 million or 9.3% from earned premiums of \$8.2 billion at 12/31/99. The change is principally caused by membership growth and rate increases that have been substantial over the past several years.

The Company reported claims incurred of \$8.2 billion at 12/31/00, an increase of \$699.0 million or 9.3%, from incurred claims of \$7.5 billion at 12/31/99. The increase in claim expenses reflects rising health care cost trends, including physician costs and prescription drugs, and increases in membership growth. The increase also reflects that currently, losses above the capped amount for the Area Rated claims are now being expensed rather than capitalized. To date, an additional \$66.1 million has been expensed in the income statement that would otherwise have been capitalized on the assets page of the balance sheet (i.e., in the Area Rated “rate stabilization reserve” balance reported as an aggregate write-in).

The Company reported a net underwriting loss of \$8.8 million at 12/31/00. The Company has historically reported underwriting losses (which are then offset by investment gains). Note that the net underwriting loss reflects that the Company currently expenses Area Rated losses. The Company now records an offset to the gross asset recorded in the aggregate write-in line on the asset page of the balance sheet. If the Company had continued to capitalize the Area Rated losses, the Company would likely have recorded a small underwriting profit.

The Company reports an aggregate write-in for other income or expenses of \$20.7 million, which represents a loss from BCN of Michigan of \$24.7 million, a gain from

The Accident Fund Company of \$4.2 million, and a loss of \$6.3 from PPOM. The balances reported for the affiliates generally represent the changes in surplus of those entities after consolidating eliminations and adjusting SAP to GAAP.

SURPLUS

The Company reports total surplus of \$1.247 billion at 12/31/00 compared to total surplus of \$1.114 billion at 12/31/99. The \$133 million or 12% increase reflects net income of \$65.4 million and net unrealized capital gains of \$67.7 million.

CASH FLOW

The nature of the Company's operations suggests a cash-based business similar to an HMO. There are, however, characteristics of a property and casualty entity given the asset base from which the Company operates. For many years, the Company has operated successfully in that underwriting income (premium revenues less benefit expenses) has either been marginally favorable or at least buoyed by strong investment returns. These investment returns had been supported by a more diverse and expansive fixed income investment portfolio. The performance over a majority of those years put the Company close to, or even above, the *maximum* surplus requirement and only Insurance Division approval to segregate affiliated surplus from BCBSM-only surplus and a raise in the surplus maximum level from 120% to 150% permitted the Company to remain at or below maximum surplus levels.

More recently, however, the Company has acquired material equity investment acquisitions that include The Accident Fund Company for \$272 million and PPOM, Inc for \$190 million. Both acquisitions were acquired for cash. The Accident Fund Company, for instance, had yet to earn BCBSM investment income in the form of cash dividends until late 1999. Note that when the Company acquired the Accident Fund Company, it had agreed not to receive dividends from the subsidiary until five years after the date of acquisition. During this period of time, therefore, a \$272 million investment, while it may have appreciated, had not earned the Company any investment income and did not, therefore, provide any source of cash inflow. Recent liquidity concerns in a market of rising healthcare costs, therefore, have been exacerbated by past investment decisions.

Cash flow, in addition, has also been affected by an increase in benefit payments that have outpaced premiums collected within the Area Rated system. This is due, likely, to higher than anticipated cost trends for the Company's underwritten business segments. These losses, until December 31, 1999, had been capitalized and reported on the balance sheet as a rate stabilization receivable (RSR). This treatment is permitted because BCBSM is a regulated entity and because the rate setting process allows the Company to recover losses in future years through rate adjustments (by increasing rates to specifically recover a percentage of the RSR in addition to other pricing adjustments). At December 31, 1999, the Company reported a RSR of \$398.9

million. This suggests that at the prior year end, the Company had a recoverable of almost \$400 million that reflects expenses that were greater than the related premiums on this business. At each annual examination, Deloitte and Touche, LLP, inquires as to the recoverability of the RSR balance. At December 31, 1999, the Company elected not to continue capitalizing and deferring future Area Rated losses. Therefore, further losses are not recorded on the balance sheet but are instead run through the income statement. This accounting change adopted by the Company largely explains the reason for the net underwriting loss reported at year-end.

There is no question that the Company is experiencing poor financial performance in sections of its Area Rated (i.e., small group business). The Company's underwriting results continue to be closely monitored by both the Financial Evaluation and Admissions Division and the Health Plans Division. It should be noted that insurers generally tolerate underwriting losses to the degree the Company is experiencing because they can invest premiums and earn investment income on those assets to more than offset the underwriting losses—which the Company is successfully doing. The Insurance Division also believes that recent rating actions on the Area Rated business signed on June 27, 2000 would alleviate the poor performance in that market segment. What the Company continues to experience, in addition to industry-wide rising healthcare costs and the battle to contain them, is financial inflexibility and lack of liquidity.